Fresh Ideas, Future Economy:

Preventative health care for our families and our future economy

Kevin Rudd MP
Federal Labor Leader

Nicola Roxon MP
Shadow Minister for Health

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Australian Labor

www.alp.org.au

Executive Summary

Good health policy is also good economic policy.

The cost of providing health care and the demand for health care are both rising.

The second Intergenerational Report estimates spending on health care will increase from 3.8 per cent of GDP in 2006-07 to 7.3 per cent in the middle of this century.

One quarter of the projected increase will be the result of the ageing population. The rest will be due to factors other than ageing, such as the increasing cost of medical technologies.[1]

In the future, demand for health services will arise from the escalating chronic disease burden of largely preventative conditions such as diabetes and cardiovascular disease.

More than 50 per cent of the Australian population already suffers from a chronic or long-term condition of some form.[2] It is estimated that three million people alone will have diabetes by 2030.[3]

The rise of these diseases poses both a major risk to the long term health of millions of Australians and a frontline economic challenge.

Poor health adversely affects work performance and productivity. It can lead to people spending a greater amount of time out of the labour force which presents personal economic challenges for individuals and their carers, and has a negative impact on the economy as a whole.

The Productivity Commission has estimated that health conditions such as cancer, cardiovascular, mental and nervous conditions, injury and diabetes reduce labour force participation rates by between around 12 and 40 per cent.

Individual chronic conditions now cost individuals and the economy significantly. For example:

- the annual financial cost of cardiovascular disease in Australia is $14.2 billion, or 1.7 per cent of GDP, including lost productivity costs of $3.6 billion;
- the estimated cost of diabetes each year is around $21 billion including lost productivity, health and carer costs, taxation revenue foregone and welfare and other payments; and
- the annual productivity loss from obesity-related illness is approximately $1.7 billion.

According to research conducted by the Australian Health Management Group, for people aged less than 45 years, those with five or more modifiable risk factors for chronic disease, such as smoking or a lack of exercise, cost the fund 2.39 times as much as a person who is ‘low’ risk. But providing care for someone over 65 with no or few health risks costs only 2.22 times as much.

[1] The Treasury, *Intergenerational Report 2007,* April 2007.
[2] AIHW, *Australia's Health 2004,* 2004.
[3] Diabetes Australia, *National Priorities for Turning Around the Diabetes Epidemic 2007-08* (http://www.diabetesaustralia.com.au).

In other words, the data suggests health status is as important a factor in determining the cost to the health system as age.[4]

The cost of treating chronic disease also rises steeply if it is not managed well. According to one estimate, the cost of treating uncomplicated diabetes is $4,000 per person per year, but this rises to $10,000 for people whose eyes, heart or circulation are affected.[5]

Many of these costs to our health system and the personal cost to Australians could be reduced or in some cases avoided altogether if chronic disease were prevented or better managed. For example, a five percent reduction in smoking prevalence would save the Pharmaceutical Benefits Scheme more than $1 billion over the long term.[6]

Importantly there is also international evidence which suggests that reducing major risks to health can also reduce social inequities. This is because many risk factors for chronic disease (such as smoking and obesity) occur most commonly in the poor and disadvantaged, who typically have fewer resources at their disposal to reduce risk factors.[7]

The current health system is very good at providing acute and episodic care when people are sick, but it is not well equipped to meet the future challenge of the growing chronic disease burden.[8]

In fact the Commonwealth Fund, a US-based health policy think tank, recently reported that Australia rates poorly – fifth out of six industrialised countries surveyed – on preventative care and chronic disease care.[9]

The Australian Institute of Health and Welfare has also found that almost one in ten hospital admissions could have been avoided with better preventative care or disease management. A staggering 552,000 Australians were taken to hospital in just one year for conditions, many of them chronic, preventable conditions that could have been avoided or better managed in the community.[10]

The Productivity Commission has estimated that with modest investments in health promotion and prevention, as many as 175,000 additional people could be in the workforce by 2030. This represents an increase of around 0.6 of a percentage point in the workforce participation rate – a substantial increase at a time of significant skills shortages around the country.

But these kind of results cannot be achieved if precious health resources are wasted on cost-shifting and duplication: as the 2004 *Governments Working Together* report completed by the Allen Consulting Group for the Victorian Government highlighted, increased emphasis on prevention, health promotion

[4] AHM Group.
[5] Cited in Julie Robotham, 'Living ourselves to death', *Sydney Morning Herald,* 14 August 2006.
[6] S.F. Hurley, M.M. Scollo, S.J. Younie, D.R. English & M.G. Swanson, 'The potential for tobacco control to reduce PBS costs for smoking-related cardiovascular disease', *Medical Journal of Australia,* vol. 181, no. 5, 2004.
[7] WHO, *The World Health Report 2002 - Reducing Risks, Promoting Healthy Life* (http://www.who.int/whr/2002/en/).
[8] J.M. Dwyer, 'Australian health system restructuring – what problem is being solved?', *Australia and New Zealand Health Policy,* vol. 1, no. 6, 2004.
[9] The Commonwealth Fund, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, May 2007.
[10] AIHW, *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions,* 2007.

and better disease management is not only important for patient care, but also for financial sustainability.[11]

Despite the obvious health, social and economic benefits of preventing chronic disease – and the growing evidence-base around the importance of prevention – only 1.7 percent of recurrent national health expenditure in 2004-05 was spent on health promotion and prevention.

Our failures to date on prevention and chronic disease management are borne out by the fact that things are actually getting worse – the prevalence of Type 2 diabetes in Australia has *doubled* since 1996.[12]

Federal Labor believes the best way to equip our health system to deal with the challenges of the future is to end the blame game and re-invigorate the role of the primary care system – the front line of the health system which provides health care to local communities.

The available research suggests that a health system oriented towards primary care delivers better health outcomes for a lower cost than one which focuses on specialist or tertiary care. For example, cross-country analyses have found that mortality rates and total health care costs are lower in countries with a strong primary care system.[13]

A Rudd Labor Government will treat preventative health as a first order economic issue. Labor recognises the importance of good health to all Australians as well as its importance in underpinning participation and productivity.

As a first step Federal Labor will:

- Establish a ***National Preventative Healthcare Strategy*** to bring a true preventative focus to the health system. The Strategy will be supported by a permanent taskforce to provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies.

- ***Shift the focus on six minute medicine*** by beginning a reform process to provide incentives for GPs to practice quality preventative health care and an increased focus on multi-disciplinary care from primary care teams.

- Broaden the focus of the major health care agreements between the Commonwealth and the States and Territories**,** to include more than just hospital funding. Labor's new agreement will include a new ***Preventative Health Care Partnership with the States and Territories***; and

- Commission the Treasury to produce a series of special ***reports on the impact of chronic disease on the Australian economy***, and the economic benefits of a greater focus on prevention in health care.

[11] The Allen Consulting Group, *Governments Working Together: A better future for all Australians*, November 2004.
[12] Diabetes Australia, *National Priorities for Turning Around the Diabetes Epidemic 2007-08* (http://www.diabetesaustralia.com.au).
[13] J. Doggett, *A New Approach to Primary Care for Australia,* Centre for Policy Development, June 2007.

Introduction

The health of the Australian community is at a cross roads.

Advances in health and science over the last century have led to dramatic improvements in the health of our population. The last few decades have seen further, exponential improvements as a result of medical research and technology. People no longer get polio. Women rarely die during child-birth. People frequently survive cancers and heart disease which a couple of decades ago would have killed them. And Australians are living longer than they ever have before.

But the gains of the last century will be swamped if the new and emerging risks of the 21st century are not recognised.

While medical knowledge has allowed us to cure and better treat many existing ailments, our lifestyles have fundamentally changed, and a tsunami of modern chronic diseases is just off shore – threatening the future health and prosperity of our community.

As a result of changed lifestyles the incidence of chronic disease has exploded – for example, the prevalence of Type 2 diabetes in Australia has *doubled* in the last decade.

The cross roads we have reached in Australia's health is a generational one.

What must we do now to ensure that the health of the next generation will continue to improve?

Importantly for Indigenous Australians – how can we have an impact within a generation to turn around the shameful life expectancy gap between Indigenous and non-Indigenous Australians?

The challenges of a new century must be tackled by a new generation health system.

As the community ages, how we maximise the health and productivity of each Australian will become increasingly important.

We are fortunate in this country to have had a Federal Labor Government with the foresight to establish Medicare – a vital and central plank in the delivery of universal health services across this country.

While maintaining Medicare's centrality and universality, we need to enhance, strengthen and modernise it to ensure that the changing needs of the community continue to be met.

This does not mean rationing access or reducing benefits to individuals, but rather increasing our commitment to maintaining good health for the whole population and ensuring our system delivers appropriate health services to everyone.

Our current system does not adequately support doctors to provide preventative health services and chronic disease management. A system designed for treating people only once they are sick will not be sufficient to tackle the growing disease burden that could be prevented if intervention occurred *before* people become ill. For our health system to remain truly universal, managing chronic disease and preventing it where possible needs to

become one of its central planks.

Keeping people well, in addition to treating and managing those who are ill, must become an express, dual purpose of Australia's health system. This objective needs to underpin both the Australian Health Care Agreements and Medicare.

If it doesn't, our hospitals and health system will come under increasing strain, and we won't be able to maintain the general health and life expectancy gains we have made in the last century.

The current Federal Government sees the most direct benefit of any prevention activity going to the states, because increased effort on prevention will ease pressure on state-government-run public hospitals. But this view is short-sighted as it ignores the impact of ill health on workforce participation and taxation revenue, and therefore the benefits to the nation from improving preventative health care.

We already know the health of Australians is tied directly to our economic productivity. Health is a major indicator of participation in the workforce, and a major indicator of productivity for those in the workforce. Productivity can only be built on the strong foundation of a healthy workforce.

But the reality will hit home more forcefully if our skills shortage worsens, the community ages and if the number of people with chronic disease continues to balloon.

Therefore, good health increasingly has a crucial role to play in securing Australia's economic future.

As Federal Labor has already made clear, education is the building block of a productive nation. Education is a core component of building human capital and the nation's prosperity. This is why we are committed to an *Education Revolution.*

Good health, like quality education, is a source of economic growth. As the National Reform Agenda has highlighted, health, like education, is a fundamental component of building human capital.

Federal Labor's commitment today to put preventative health care for our families' front and centre writes the next chapter of Labor's health story.

This is a proud story that started in the modern era with Medibank and Medicare. Federal Labor's introduction of Medicare changed the way Australians saw health care. Before Medicare, access to quality, affordable health care was never guaranteed; with Medicare, it became an Australian birthright.

Medicare is built on the principle that every Australian, when they fall ill, should be able to get the help they need, when they need it. Federal Labor is fundamentally committed to the principle of universal access to care and to retaining and improving Medicare.

We also recognise and support the increased role the private sector currently plays in delivering health and medical services to the population – complementing our strong public system.

But with the rising threat of chronic diseases, Australia can no longer afford to treat health care only as something we do *after* we fall ill.

We must take decisions now to protect our long-term economic security.

The health of our population, and of our workforce, cannot be ignored any longer.

A Rudd Labor Government will build on the Labor reforms of the past, and re-shape the health system to deal with the challenges of the future, in particular the challenge of preventable illness. We need to re-focus the health system towards preventative health care in order to get the best health outcome for Australians, a more productive workforce, and the most out of each health dollar.

In short, a Rudd Labor Government will make preventative health care and health promotion a major focus of the health system. Our goals will be to:

- maximise the population of healthy and productive members of the community;
- ensure the health of the next generation is better, not worse, than ours; and
- close the gap in Indigenous life expectancy.

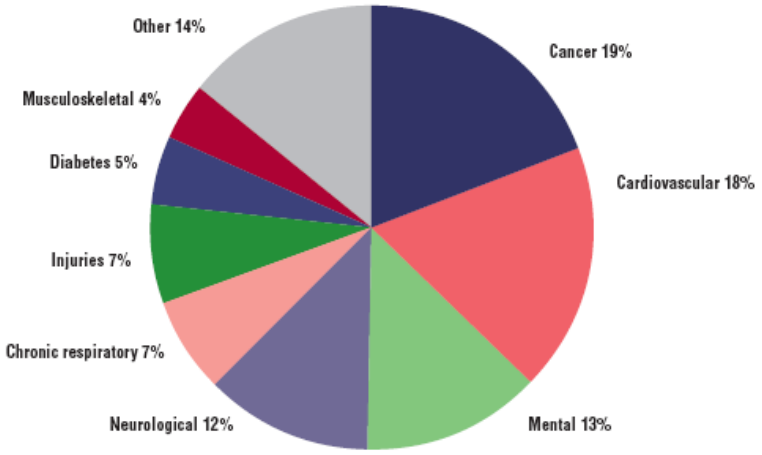
Illnesses of the 21st century

This section of the paper highlights the likely impact for future generations of Australians if we do not take action now to address the growing burden of chronic disease.

The growing burden of chronic disease is this century's critical health challenge.

'Diseases of affluence' such as diabetes, cardiovascular diseases, some cancers (for instance of the lung and bowel) and asthma, as well as other health conditions such as mental health problems, make up a significant proportion of the diseases which constitute the majority of the total 'disease burden' in Australia.

Leading causes of disease burden in Australia: 2003



Source: Australian Institute of Health and Welfare, The burden of disease and injury in Australia 2003 (2007).

The disease burden is the years of life lost due to premature death as well as years of healthy life lost due to disability.[14]

Many factors contribute to the rise of chronic disease, but among these we know that current eating habits (more fat and sugar), the changing nature of work (less physical labour and activity but more stress), and modern life in general (more sedentary leisure activities, and heavier reliance on cars) all contribute to lifestyles that have started to make our population less healthy.

Some links – such as the one between smoking and lung cancer – are well established. Others – such as the link between preservatives and asthma, and between obesity and asthma – are less so.

But the important message about almost all of these conditions – that is, the thing they have in common – is that each condition has a set of *modifiable* risk factors. Smoking and overweight/obesity are key among these – particularly to heart disease, lung and bowel cancer, diabetes, and stroke.

Simple policy action can be taken to reduce these risk factors, which would significantly improve the health of the population.

Modern science has given us the knowledge and tools to modify those actions which increase our risk of illness. We can affect preventable disease by our own behaviour. But recent history demonstrates that even while most of us already know this, we sometimes need motivation, resources, support and help from the system to turn this knowledge into practice.

The extent of preventable illness

Cardiovascular diseases (including heart, stroke and blood vessel disease) are the leading cause of death in Australia – almost 50,000 people died as a result of cardiovascular disease in 2004. While there have been significant

[14] AIHW, *The burden of disease and injury in Australia 2003*, 2007.

improvements in death rates, levels of some risk factors and treatment outcomes over recent years, cardiovascular disease is still a leading cause of disability in Australia, with 6.9 per cent of the population estimated to have disability associated with cardiovascular problems or conditions.

Around 3.5 million Australians – close to 20 per cent of the population – were affected by cardiovascular diseases in 2004-05. Direct health care expenditure on cardiovascular disease is higher than for any other disease group. Cardiovascular disease disproportionately affects Indigenous people and people who are socioeconomically disadvantaged.[15]

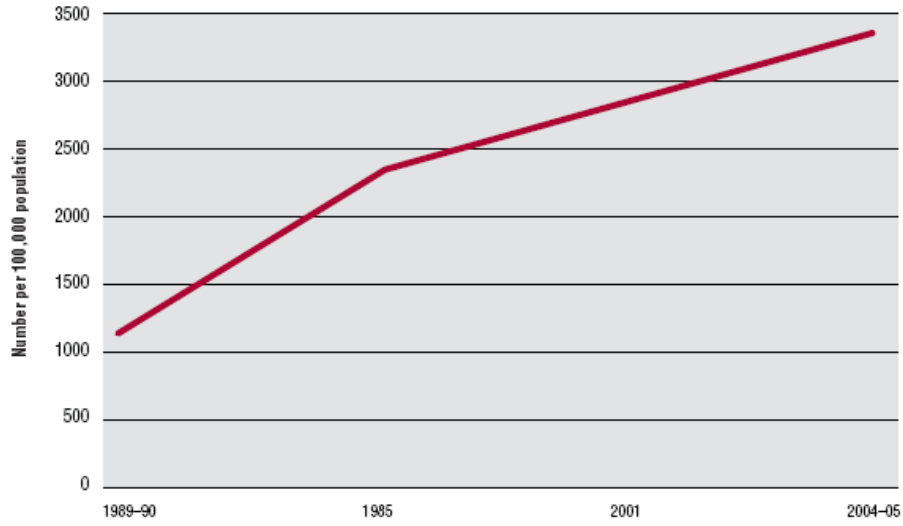
Skin cancer, an almost entirely preventable condition, accounts for around 81 per cent of all new cancers diagnosed each year in Australia. Around 380,000 people are treated for skin cancer each year and approximately 1400 people die. Melanoma is the most common form of cancer in people aged 15 to 44 years in Australia, and the third most common cancer in women and the fourth most common in men.[16] Melanoma rates in Australia are the highest in the world.[17]

Bowel cancer is a frequent cause of death for Australian men and women. There are over 10,000 new cases diagnosed, and around 4,500 deaths, from bowel cancer each year.[18] The rate of bowel cancer in women is projected to increase in the future.[19]

Approximately 850,000 Australian adults have Type 2 diabetes.[20] Alarmingly, the prevalence of Type 2 diabetes in Australia has *doubled* in the last decade. By 2031, it is predicted that a staggering three million Australians will have diabetes.[21] And most concerning of all, Type 2 diabetes – which used to be called adult onset diabetes – is now increasingly being diagnosed in children.

[15] AIHW, *Heart, stroke and vascular diseases—Australian facts 2004*, AIHW and National Heart Foundation of Australia, 2004.
[16] The Cancer Council Australia (http://www.cancer.org.au).
[17] Australian Cancer Research Foundation (http://www.acrf.com.au).
[18] AIHW, Chronic diseases website (http://www.aihw.gov.au/cdarf/diseases_pages/index.cfm).
[19] AIHW, *Cancer incidence projections Australia 2002 to 2011,* 2005.
[20] AIHW, Chronic diseases website (http://www.aihw.gov.au/cdarf/diseases_pages/index.cfm).
[21] Diabetes Australia, *National Priorities for Turning Around the Diabetes Epidemic 2007-08* (http://www.diabetesaustralia.com.au).

Trends in the prevalence of diabetes: 1989–90 to 2004–05



Source: Australian Institute of Health and Welfare, Australia's Health 2006 (2006).
Note: Figure is based on self-reported data age-standardised to the 2001 Australian population.

People whose diabetes is not managed well are two to five times more likely to have a heart attack or stroke.[22] Stroke is one of Australia's biggest killers: there are around 50,000 strokes occur each year, claiming around 12,000 lives.[23]

Diabetes that is not treated well can also lead to chronic kidney disease – the long-term loss of kidney function. It is a significant contributor to mortality and disability in Australia, especially amongst the Indigenous population. In 2003, chronic kidney disease was recorded as the underlying cause of death in 2,431 cases and an associated cause of death in a further 9,217 cases.[24] However, it is difficult to know exactly how many people in Australia suffer from chronic kidney disease because it has few specific, obvious symptoms and is often not detected until the very late stages.[25]

The prevalence of asthma in Australia is among the highest in the world: it affects up to 14 per cent of children and 10–12 per cent of adults. The incidence of asthma in Australia increased during the 1980s and 1990s, though the latest evidence suggests that asthma rates have plateaued.[26]

One in five Australians this year will experience some form of mental illness such as depression, which is now the most disabling illness in our community. Of all the health problems affecting Australian society, 13 per cent are mental health problems. Of all disability costs in Australia, 27 per cent are from mental health problems. About 20 per cent of Australian adults will be affected by a mental health problem each year; 3 per cent will be seriously affected.

Based on self-reported data, around 1.4 million people in Australia have osteoarthritis (the most common of the arthritis conditions). This condition results from the breakdown of cartilage in the joints. Osteoarthritis is caused by obesity, physical inactivity, repetitive occupational joint use, and/or joint trauma and injury.[27]

[22] AIHW, *Australia's Health 2006,* 2006.
[23] AIHW, *Australia's Health 2006,* 2006.
[24] AIHW, *Chronic Kidney Disease in Australia 2005*, 2005.
[25] AIHW, *Australia's Health 2006,* 2006.
[26] Australian Government *Health Insite* website (http://www.healthinsite.gov.au).
[27] AIHW, Chronic diseases website (http://www.aihw.gov.au/cdarf/diseases_pages/index.cfm).

There are several risk factors which contribute to many of these conditions:

- according to the most recent data 17 per cent – almost one-fifth of the population – smoke daily;[28]

- in 2005 *3.24* million Australians were estimated to be obese – 1.52 million males (15.1 per cent of all males) and 1.72 million females (16.8 per cent of all females);[29]

- despite what we know about the value of exercise in mitigating the risk factors that lead to diseases such as diabetes and heart disease, 60 per cent of Australian adults are overweight and 54 per cent of Australian adults are not sufficiently active to gain a health benefit from the exercise they undertake;[30] and

- excessive consumption of alcohol is a major risk factor for morbidity and mortality: it is estimated that in Australia harm from alcohol was the cause of 5.3 per cent of the burden of disease for males and 2.2 per cent for females.[31]

It is important to note that a comprehensive approach to minimising tobacco consumption (including advertising bans, anti-smoking laws, warning labels on cigarette packets, and the state-based Quit programs) has led to an improvement in smoking rates. The proportion of the Australian population aged 14 years and over who were daily smokers dropped from 24 per cent in 1991 to 17 per cent in 2004.[32] Though it must be noted that smoking rates are still very high among some groups in the population, for example in Indigenous communities.

Obesity rates, however, have increased markedly in the last decade and a half: between 1980 and 1999–2000 the proportion of obese men aged 25–64 years and living in Australian capital cities and urban areas increased from 9.4 per cent to 16.9 per cent. In the same period the obesity rate among women aged 25–64 years rose from 7.9 per cent to 19.8 per cent.[33] Access Economics forecasts there could be as many as 7.2 million obese Australians by 2025 (28.9 per cent of the population).[34]

There is another important fact to note in all this data – the pain of chronic disease does not fall evenly on the population.

For example, in 2001-03, death from diabetes and diabetes-related illnesses in the most disadvantaged areas of Australia was 82 per cent higher than in the least disadvantaged areas.[35]

Nowhere is this more obvious than when it comes to the Indigenous population, who not only suffer much higher rates of chronic disease than do the non-Indigenous population, but their treatment outcomes tend to be much poorer as well.

[28] AIHW, *Statistics on drug use 2006,* 2007.
[29] Access Economics, *The Economic Costs of Obesity,* October 2006.
[30] AIHW, Heart Week 2006 (http://www.aihw.gov.au/cvd/heartweek/heartweek2006.cfm).
[31] AIHW, *Australia's Health 2006,* 2006.
[32] AIHW, *Statistics on drug use 2006,* 2007.
[33] AIHW, *A growing problem: trends and patterns in overweight and obesity,* 2003.
[34] Access Economics, *The Economic Costs of Obesity,* October 2006.
[35] AIHW, *Australia's Health 2006,* 2006.

Australians living in rural and remote areas also have higher rates of many risk factors for chronic disease, and in most cases, more difficulty accessing the health care they need once chronic diseases develop.[36]

An increased focus on preventative care and chronic disease management will benefit everyone in the community. But as people from lower socio-economic and other disadvantaged groups have higher rates of many chronic diseases, an increasing focus on preventative care will also help address social disadvantage as well as result in more equitable health outcomes.

Fairness and compassion, as much as the needs of our economy, demand that attention be given to this social injustice and health inequity.

Indigenous health

Rates of all preventable chronic diseases are higher in the Indigenous population. Indigenous people are also more likely to experience 'complex co-morbidities' – that is, to have more than one of these conditions. Treatment outcomes for Indigenous people with chronic disease are also poorer than for the rest of the population. For instance:[37]

- Indigenous people are much more likely to die from heart disease than other Australians, particularly in younger age groups: the cardiovascular disease death rate among Indigenous people aged between 25 and 54 years is at least 9 to 10 times, and possibly as high as 13 times, that of other Australians.

- Indigenous people experience among of the highest rates of acute rheumatic fever and chronic rheumatic heart disease in the world. These conditions are almost unknown outside the developing world.

- Indigenous people are more likely to be hospitalised for, and die from, respiratory diseases.

- Indigenous people are more likely to die from cancer than are non-Indigenous people (though notification rates for new cases of cancer have been lower for Indigenous people than for non-Indigenous people).[38]

- Type 2 diabetes is between two and four times more common among Indigenous people than among non-Indigenous people. Indigenous people are likely to be diagnosed with diabetes at a much lower age than non-Indigenous people, and deaths from diabetes are much more common for Indigenous people than for non-Indigenous people. Recent evidence suggests the problem may actually be getting worse: research published recently in the *Medical Journal of Australia* shows significant increases in Body Mass Index (BMI) – a major risk factor for Type 2 Diabetes – among the Torres Strait population between 1999 and 2005.[39]

- Related to the high incidence of diabetes are very high rates of renal disease, and in particular end-stage renal disease (when the kidneys are

[36] AIHW, *Australia's Health 2006,* 2006.
[37] Statistics taken from Australian Indigenous Health *InfoNet, Summary of Australian Indigenous Health*, November 2005 (http://www.healthinfonet.ecu.edu.au/).
[38] This may be because the kinds of cancers which tend to be predominant in the Indigenous population (such as cancers of the lung and liver) are more likely to be fatal, and/or because the stage of cancer tends to be more advanced in Indigenous people by the time it is recognised.
[39] R.A. McDermott, B.G. McCulloch, S.K. Campbell & D.M. Young, 'Diabetes in the Torres Strait Islands of Australia: better clinical systems but significant increase in weight and other risk conditions among adults, 1999–2005', *Medical Journal of Australia,* vol. 186, no. 10, 2007.

no longer able to function). This is particularly so in remote areas, where rates of renal disease are up to 30 times higher for Indigenous people than they are for non-Indigenous people, but also where access to renal dialysis is very limited.

Indigenous people as a population also have far higher levels of the key chronic disease risk factors. For example, according to the 2001 National Health Survey, over 50 per cent of Indigenous people over 18 years old smoke, compared to 24 per cent of non-Indigenous people. Smoking rates among Indigenous people are particularly high in remote areas.[40] Indigenous peoples are also more likely than non-Indigenous people to be obese or overweight.[41]

Most shameful of all, Indigenous people have a life expectancy 17 years lower than that of non-Indigenous people. High rates of chronic disease and poor treatment outcomes are a major contributor to lower life expectancy among Indigenous people.[42]

The poor state of Indigenous health demonstrates the heavy burden that poorly managed chronic disease has on our society. It also powerfully demonstrates the case for doing more to prevent it in the first place.

Are we looking at ageing in the wrong way?

There is a common perception that as the proportion of the population aged over 65 increases, the more we will need to spend on health care and the less people there will be in relative terms to contribute to the taxation revenue necessary to meet this cost.

However, as noted by the Productivity Commission, several prominent economists have suggested that the influence of ageing on future health expenditure is often overstated.[43]

It is certainly the case that our ageing population has a significant effect on health expenditure and will continue to do so in the future. This is not least because the prevalence of chronic conditions such as dementia will increase as the population ages. The AIHW estimates that 171,000 people over 65 had dementia in 2004;[44] Access Economics forecasts an increase to 730,000 by 2050.[45]

Missing from this argument is an acknowledgment that preventable chronic diseases are fast becoming an equally important driver of increased health expenditure in their own right.

The Intergenerational Report (IGR) released in April this year foreshadows an increase in Australian Government health spending as a proportion of GDP, from 3.8 per cent in 2006-07 to 7.3 per cent in 2046-47. Health is one of the biggest drivers of projected increases in spending due to demographic factors.

[40] Australian Indigenous Health *InfoNet* (http://www.healthinfonet.ecu.edu.au/).
[41] Australian Indigenous Health *InfoNet* (http://www.healthinfonet.ecu.edu.au/).
[42] Y. Zhao & K. Dempsey, 'Causes of inequality in life expectancy between Indigenous and non-Indigenous people in the Northern Territory, 1981–2000: a decomposition analysis', *Medical Journal of Australia,* vol. 184, no. 10, 2006.
[43] Productivity Commission, *Economic Implications of an Ageing Australia*, Productivity Commission Research Report, March 2005.
[44] AIHW, *Australia's Health 2006,* 2006.
[45] Access Economics, *Dementia Estimates and Projections: Australian States and Territories*, February 2005.

However, the IGR also points out that *non*-demographic factors (such as the cost of medical technology), rather than population growth or ageing, have been the key drivers of real health spending over the past two decades, and are likely to 'continue to generate the greatest cost pressure in the future'.[46]

One of the shortcomings of the first IGR was its failure to assess the economic impact of chronic and preventable disease: that is, on future health expenditure, workforce participation and productivity.

Remarkably, an assessment of the impacts of chronic and preventable disease was also omitted from the second Intergenerational Report released this year, even though economic analysis has identified health status as an important predictor of labour force participation.[47]

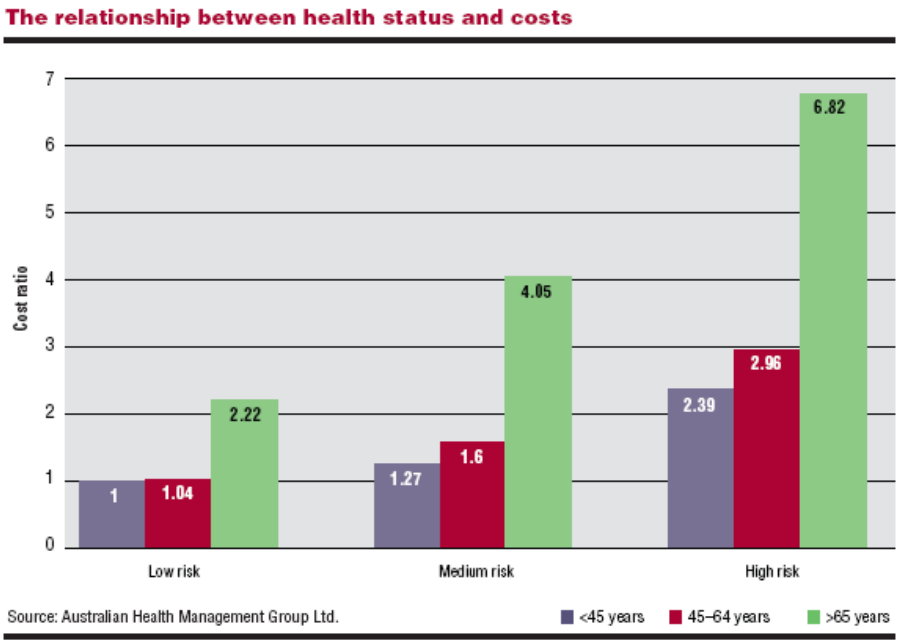
What is also missing from the current debate is recognition that the current rise in younger people with chronic disease may place greater stress on our health system in the immediate future than our ageing population.

Research conducted by the Australian Health Management (AHM) Group – one of the Australia's ten biggest private health insurers – helps to make this point.

Data from AHM shows that of people aged under 45 years, a person with 5 or more modifiable risk factors (including smoking and lack of exercise) costs the fund 2.39 times as much as a person who is 'low' risk (someone who has 0-2 risk factors).[48]

As the following figure shows, according to AHM's data, the cost of providing health care to someone aged 65 years or over and 'high risk', is 6.82 times the amount required to assist a young person with few or no risks. But the cost of care for someone over 65 with few or no risks is only 2.22 times that of providing health care for someone younger. This suggests that health status is a more important factor in determining the cost to the system of providing health care than age.[49]

[46] The Treasury, *Intergenerational Report 2007,* April 2007.
[47] See, for example, L. Cai and G. Kalb (2006), 'Health Status and Labour Force Participation: Evidence from the HILDA Data,' *Health Economics,* 15(3), pp. 241-261.
[48] AHM Group.
[49] AHM Group.



Of course it is entirely appropriate that we invest more in older, sicker people more than younger, healthier people. However, it is worth noting that older, healthier people might actually cost the health system *less* than young, unhealthy people.

Around 12.5 per cent of the population is now over the age of 65. As the ageing of the population continues, by 2047 the proportion of the Australian population aged 65 and over will increase to 25 per cent.[50]

But according to the AIHW, over 50 per cent of the Australian population *already* has a chronic or long-term condition such as cardiovascular disease, cancer, diabetes, asthma, injury, or arthritis.[51] Depending on which conditions are included, this figure could in fact be as high as 77 per cent.[52]

As a proportion of the population, there are already more people with chronic disease than there will be people over 65 in 40 years.

Obviously, we can't stop the ageing process. But we *can* stop many people becoming unhealthy – both young and old.

And we should, because chronic disease and preventable illness will continue to have a dramatic impact on health and workforce participation and productivity if we do not.

The cost of doing nothing

Chronic, preventable disease is now a major driver of increasing health expenditure in its own right.

[50] The Treasury, *Intergenerational Report 2007,* April 2007.
[51] AIHW, *Australia's Health 2004,* 2004.
[52] AIHW, *Chronic diseases and associated risk factors, 2006*, 2006.

In 2005, Access Economics estimated the annual financial cost of cardiovascular disease in Australia at $14.2 billion, or 1.7 per cent of GDP. This figure includes lost productivity costs of $3.6 billion, caused by lower employment rates and premature mortality. In addition to the financial costs, Access Economics estimates the value of suffering and premature death from cardiovascular disease at a staggering *$94 billion*.[53]

The estimated total cost of diabetes sits at around $21 billion. This figure includes lost productivity, health and carer costs, taxation revenue foregone and welfare and other payments. People with Type 2 diabetes have significantly lower productivity in the workplace; lower workforce participation rates; and are more likely to suffer from heart disease.[54]

The following table from a recent Productivity Commission report highlights the impact of chronic conditions on labour force participation rates.

Labour force participation rates by health condition: 2001–04

Condition	Cancer	Cardio-vascular	Mental/ nervous	Major injury	Diabetes	Arthritis
Total population	%	%	%	%	%	%
Does not have condition	80.3	82.0	80.7	80.2	80.7	82.6
Has condition	68.6	64.0	39.3	60.1	56.6	63.1
Males						
Does not have condition	89.0	90.8	89.0	88.6	89.1	91.2
Has condition	67.8	70.6	37.5	67.1	64.6	68.0
Females						
Does not have condition	72.3	74.1	73.0	72.5	72.8	74.5
Has condition	69.4	56.7	40.8	52.1	46.0	59.3

Source: Productivity Commission, Effects of Health and Education on Labour Force Participation, Staff Working Paper (2007).

Participation rates are significantly lower for each of the conditions listed in the table. Mental or nervous conditions have the greatest effect on participation rates: participation rates for people who have a mental or nervous condition are less than half those for people who don't have a mental or nervous condition. The difference is even more pronounced for males.[55]

Poor health is not just associated with lower participation rates, but also with lower productivity: people in poor health tend to be less productive when they are at work, because, not surprisingly, poor health negatively affects work performance.

For example, mental health problems such as depression can not only cause absenteeism but also impair motivation and work performance.[56]

The stigma attached to mental health conditions can also have a debilitating effect on participation rates: people with depression, for example, may face limited employment opportunities if an episode of 'impaired motivation' caused by depression is interpreted by employers as reflective of an overall low level of motivation, or if employers assume all people with depression have low levels of motivation all the time.[57]

[53] Access Economics, *The shifting burden of cardiovascular disease in Australia,* 2005.
[54] Access Economics, *The Economic Costs of Obesity,* October 2006.
[55] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[56] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[57] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.

But the Productivity Commission points out that the reverse is also true: 'healthy workers can expect higher returns from work and, as a result, have a greater incentive to be in the labour force'.[58]

Subsequently, the cost of inaction on prevention and early intervention is significant.

In the case of mental health, for example, early intervention can lead to better recognition and management of risk factors, which can prevent some problems from developing or reduce their severity.[59]

Last year Access Economics estimated that the total cost of obesity in Australia in 2005 was $21 billion. This includes productivity losses of $1.7 billion, as a result of absenteeism, lost management productivity, long-term lower employment rates, and premature death; as well as the cost to the health system of obesity-related illness, and a range of indirect costs such as lost wellbeing.[60]

And the list could go on.

The direct costs to the health system of chronic disease are also substantial. For example, Access Economics estimated in 2005 that the annual cost to the health system of cardiovascular disease alone is $7.6 billion, and this figure is projected to increase to $11.5 billion by 2011.[61]

Yet many of these costs could be reduced or in some cases avoided altogether if chronic disease were prevented or better managed.

According to research published in the *Medical Journal of Australia* in 2004, the cost to the Pharmaceutical Benefits Scheme of smoking-related cardiovascular disease in 2001-02 was $126 million. The authors of this study also estimated that a 5 per cent reduction in smoking prevalence would save the Pharmaceutical Benefits Scheme over $1 billion over the long term.[62]

The cost of treating chronic disease also rises steeply if it is not managed well. According to one estimate, the cost of treating uncomplicated diabetes is $4,000 per person per year, but this rises to $10,000 for people whose disease has affected the eyes, heart or circulation.[63]

The Access Economics report on obesity found that the direct financial costs of obesity-related illness in 2005 (including money spent through the health system on treating obesity-related illness) was over $3.7 billion.[64] This amount could be significantly reduced if a serious effort was made to tackle obesity in Australia.

It is time that we properly recognised the impact of preventable and chronic diseases on Australia's economy and productivity.

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[58] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[59] The Allen Consulting Group, *Governments Working Together: A better future for all Australians*, November 2004.
[60] Access Economics, *The shifting burden of cardiovascular disease in Australia,* 2005.
[61] Access Economics, *The shifting burden of cardiovascular disease in Australia,* 2005.
[62] S.F. Hurley, M.M. Scollo, S.J. Younie, D.R. English & M.G. Swanson, 'The potential for tobacco control to reduce PBS costs for smoking-related cardiovascular disease', *Medical Journal of Australia,* vol. 181, no. 5, 2004.
[63] Cited in Julie Robotham, 'Living ourselves to death', *Sydney Morning Herald,* 14 August 2006.
[64] Access Economics, *The Economic Costs of Obesity,* October 2006.

It is also time that we recognised the need to place prevention at the centre, and not at the margins, of our health policies.

While failure to tackle chronic disease represents a cost, the benefits of better addressing chronic disease represent an economic opportunity.

This is why investing in human capital through a greater focus on prevention of chronic disease and health promotion was one of the central planks of the Council of Australian Governments' National Reform Agenda designed by the Victorian Government.

The Productivity Commission has estimated that modest investments in health promotion and prevention will deliver improvements in workforce participation and national productivity. For example, the Productivity Commission estimates that around 100,000 deaths could be avoided by 2030 through improved health promotion and disease prevention.[65]

The Productivity Commission also estimates that improved health promotion and prevention could result in as many as 175,000 extra people in the workforce by 2030, due to reduced mortality and incapacity, as well as an associated reduction in the need for carers. These extra workers would represent an increase of around 0.6 of a percentage point in the workforce participation rate – a substantial increase at a time of significant skills shortages around the country. The biggest gains stand to be made by improved prevention and management of mental health, cardiovascular disease, and Type 2 diabetes, as the following table shows.[66]

Estimates potential workforce effects from improved health outcomes: 2030

Chronic disease	Increased participation		Relative productivity
	Number	% points	%
Mental health	101,000	0.46	70
Cardiovascular	30,000	0.01	100
Type 2 diabetes	31,000	0.07	100
Injury (serious)	8,000	0.03	100
Cancer	6,000	-0.01	100
Musculoskeletal	1,000	0.00	100
Less double up	2,000	0.01	100
Total	**175,000**	**0.55**	**83**

Source: Productivity Commission, Potential Benefits of the National Reform Agenda.
Notes: The total against the 'relative productivity' column is a weighted average.
Adjustment is made for co-morbidities in the 'less double up' row.

Preventative health is not simply good sense – it is good economic policy.

In addition to the health and economic benefits, there is now international evidence which suggests that reducing major risks to health can also reduce social inequities. This is because many risk factors for chronic disease (such as smoking and obesity) occur most commonly in the poor and disadvantaged, who typically have fewer resources at their disposal to reduce risk factors.[67]

[65] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[66] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[67] WHO, *The World Health Report 2002 - Reducing Risks, Promoting Healthy Life* (http://www.who.int/whr/2002/en/).

Yet according to a recently released report from the Commonwealth Fund, a US-based health policy think tank, Australia rates poorly – fifth out of six industrialised countries surveyed – on preventative care and chronic disease care.[68]

Failure to invest in prevention and chronic disease management means we are failing to invest in the economic security of our nation by failing to invest in the health of future generations of Australians.

What is going wrong now?

The current health system, struggling under the weight of the growing chronic disease burden, is fragmented and does not meet the needs of many people with complex conditions very well.[69]

Without reform, Australia's health system will be forever caught in a vicious cycle – with constant demands for more and more money to be poured into acute and episodic care and scant attention paid to stemming the flow of illness and preventing hospitalisation in the first place.

The current system is very good at providing acute and episodic care, but it is not well equipped to meet the challenge of the growing chronic disease burden.[70]

We need to build on the foundations of the existing system by enhancing its capacity to deal with preventable chronic disease.

This century's challenge is not about taking resources away from acute care (particularly hospitals) but about complementing these resources with a greater focus on prevention. For example, there is now a strong evidence base around the prevention of diabetes in people with pre-diabetes. A greater focus on preventing prediabetes progressing to Type 2 diabetes would be preferable for patients but also save the health system down the track.[71]

As the chronic disease burden grows and the community ages, the system in its current form will not be sustainable. We must find ways to keep more people healthy and out of hospital.

Medicare was designed by Labor to provide universal access to medical services. But under-investment in updating the Medicare structure means that cracks are starting to appear in the system – political fixes and targeted incentives without comprehensive long term planning have created a Medicare Schedule that is hundreds of pages long and includes thousands of different item numbers.

As a result, doctors are spending too much of their precious time wading through the red tape, rather than helping their patients.

Governments of the future need to consider the complexity this situation has created. And importantly, governments of the future need to grapple with the core issue that a system designed *only* around treating people when they are ill

[68] The Commonwealth Fund, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, May 2007.
[69] J.M. Dwyer, 'Australian health system restructuring – what problem is being solved?', *Australia and New Zealand Health Policy,* vol. 1, no. 6, 2004.
[70] J.M. Dwyer, 'Australian health system restructuring – what problem is being solved?', *Australia and New Zealand Health Policy,* vol. 1, no. 6, 2004.
[71] Australian Government *Health Insite* website (http://www.healthinsite.gov.au).

will not necessarily encourage the proper professional attention needed for a growing disease burden that could be prevented if intervention occurred before people were ill.

The AMA argues, for example, that the current Medicare schedule requires reform so doctors are rewarded for longer consultations necessary to deliver the type of comprehensive care needed for people with chronic diseases.[72] Doctors have complained that the schedule as it is currently constructed encourages '6 minute medicine' – that is, a greater number of shorter consultations rather than fewer longer consultations.[73]

National figures on Medicare benefits by region show clear areas of under-utilisation: many communities miss out on their share of Commonwealth funds because of structural barriers, workforce shortages, and in some cases, inability to meet ever-increasing co-payments. This is most apparent in data on Indigenous take-up of Medicare services: average Medicare benefits per capita for the Indigenous population are less than half of those for non-Indigenous Australians. Pharmaceutical benefit payments per capita are less than a third of those for non-Indigenous Australians.[74]

Lack of integration between hospital and primary care services means that the system does not always adequately support continuity of care, particularly for people with chronic disease.

What does all this mean for patients?

People with chronic conditions waste valuable time and resources negotiating their way through an uncoordinated health care system. Often they struggle to find out what health care options are available to them and what mix of services would achieve the best outcome. They are shuttled from one health care provider to another, often required to duplicate tests and repeat the same information each time they encounter a new health care provider.

Rushed health professionals, constrained by a Medicare Schedule that hasn't kept pace with the changing needs of the community, means that doctor-patient consultations often feel hurried. Discussions about complex issues like modifying chronic disease risk factors behaviour don't happen easily in such settings.

People are also frustrated by having to make multiple, separate trips to the doctor and other health professionals such as specialists or allied health workers. Each trip takes time, money and travel – so people often just don't bother.

This means that people with chronic conditions often don't get the extra help they need to get better more quickly, or stop getting sick in the first place.

The experience people with chronic diseases have of the health care system is very different from that of people receiving acute care – we need to listen and learn from them in developing a health care system that is also geared to the treatment of their chronic conditions, or preventing them in the first place.

The blame game

[72] AMA Federal Budget Submission 2007-08 - Quality Health Care For All Australians (http://www.ama.com.au).
[73] See, for example, J. Beilby, *Final report of the attendance item restructure working group*, 2003.
[74] AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02,* 2005.

The design of our health system in the Federation means that there aren't sufficient incentives for governments – Commonwealth and state and territory – to invest more in prevention.

The current division of responsibilities between levels of government means that, even though the Commonwealth is the major financer of primary care – where the most gains stand to be made in prevention and chronic disease management – there is little incentive for a Commonwealth Government to invest in better prevention because the most obvious pay-offs will be enjoyed by the states and territories, as the managers of the public hospital system.

In other words, Commonwealth failure to invest in preventative care leaves the states bearing the most immediate burden of the cost.

But ultimately this is a short-sighted approach. As the National Reform Agenda has made clear, there would be significant benefits to the Commonwealth of greater investment in human capital, including investment in prevention and better chronic disease management. These benefits include higher rates of workforce participation and productivity, and a resultant increase in taxation revenue.[75]

The states and territories, meanwhile, are focused on managing the hospital system, and do not have the financial levers to play a greater role in re-orienting the system to focus on chronic disease management and prevention.

And in all of this, cost-shifting between Commonwealth and state and territory governments is endemic.

A recent report from the AIHW delivered some of the most compelling evidence yet that the blame game between the states and the Commonwealth is hurting our health system – and hurting patients.

According to the AIHW, almost one in ten hospital admissions could have been avoided with better preventative care or disease management. A staggering 552,000 Australians were taken to hospital in just one year for conditions that could have been avoided. Most of these admissions were due to chronic diseases, for example circulatory and respiratory conditions and complications from diabetes, which could have been better managed in the community.[76]

Surely it is fair to ask: if we know these hospitalisations are preventable – and we also know *how* to prevent them – then shouldn't we simply invest the money in preventing them?

Even simple problems like when patients are discharged from hospital, there is no assurance of co-ordination of their medicines, their ongoing care or strategies to prevent readmission. Though some regions, hospitals and even individual professionals (like doctors and pharmacists) are taking initiative at local levels.

Many patients also have to return to hospital for access to follow-up services when it would aid their recovery to be elsewhere.

These sorts of inefficiencies produce less than optimal outcomes for patients.

But they also mean that precious health resources are wasted on cost-shifting and duplication. As the 2004 *Governments Working Together* report completed

[75] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[76] AIHW, *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions,* 2007.

by the Allen Consulting Group for the Victorian Government highlighted, increased emphasis on prevention, health promotion and better disease management is not only important for patient care, but also for financial sustainability.[77]

Cost-shifting, duplication and inefficiencies cause great frustration for our health professionals who must work within some peculiar boundaries due to the division of responsibilities between states and territories and the Commonwealth.

And although it is difficult to quantify the precise cost of current inefficiencies, some estimates put it as high as $4 billion annually.[78] This is money that could be spent more effectively if waste and duplication were reduced.

Piecemeal approach to prevention

Some states are trying to tackle the problems. For example, Victoria has proposed a comprehensive plan to tackle Type 2 diabetes. This received some support at COAG and from the Commonwealth Government in the 2007 federal budget, but too often governments pick winners rather than focus on the bigger picture.

Some worthy inititiaves have been introduced by the Commonwwealth Government. For example, the preventative health checks now on the Medicare schedule for some age groups, the expansion of private health insurance to cover some preventative services, and the funding in the recent federal budget for longer specialist consultations for people with chronic diseases – but overall the approach is piecemeal.

The National Chronic Disease Strategy and COAG Better Health Initiative were positive steps towards a more comprehensive approach but progress in implementation has been slow.

Despite the obvious health, social and economic benefits of preventing chronic disease – and the growing evidence-base around the importance of prevention – still only 1.7 per cent of recurrent national health expenditure in 2004-05 was spent on health promotion and prevention.

Our failures to date on prevention and chronic disease management are borne out by the fact that things are actually getting worse, demonstrated by the increasing prevalence of diabetes and obesity.

The design of the current system – which is designed around illness rather than health – will not be sustainable in the long term without strategic enhancements.

We need to have a public conversation about the most effective way of dealing with Australia's chronic disease challenge. It is a debate that we need to have.

The challenges of a new century must be tackled by a new generation health system.

Keeping people well, in addition to treating and managing those who are sick, must become an express, dual purpose of Australia's health system.

[77] The Allen Consulting Group, *Governments Working Together: A better future for all Australians*, November 2004.
[78] House Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding,* December 2006.

Prevention is better than cure

Despite the growing burden of chronic disease, there are many examples of proven interventions and strategies that can work both to reduce the incidence of chronic disease and the risk factors that lead to it.

Public health programs aimed at reducing tobacco consumption, for example, have led to reduced rates of lung cancer and cardiovascular disease.[79]

Good skin protection greatly reduces the risk of developing melanoma.

Adequate intake of calcium and sufficient weight bearing exercise can prevent or at least delay the onset of osteoporosis.

A healthy diet and moderate, regular exercise can prevent the onset of cardiovascular disease, Type 2 diabetes, and some cancers.

We also know that particular models of service delivery – for example, comprehensive child and maternal health services – can help to improve infant and child health, which can reduce the likelihood of the development of chronic conditions later in life. This is particularly so for disadvantaged communities, including Indigenous communities. This is why Labor recently announced a $261 million package targeting Indigenous children's health and early education.

Some of the private health funds are now starting to actively engage in preventative health and chronic disease programs, because they recognise the benefits of keeping people well and keeping them out of hospital.[80] It is salutatory that the private market has recognised the economics of prevention and the importance of looking at ways to keep their members healthy for longer.

These are just a few examples but they show that we have the wherewithal to prevent much of the chronic disease burden.

We just need the political will to build a focus within the health system on doing it.

[79] Applied Economics, *Returns on Investment in Public Health: An epidemiological and economic analysis*, March 2003.

[80] For example, the AHM group's 'Total Health' program provides advice and a range of tools to support people reaching their health goals, including weight loss, exercise goals, and better nutrition. AHM's 'Total Care' program also provides customised case management for people with chronic or complex illnesses or conditions (http://www.ahm.com.au).

Next generation health: prevention through primary care

The most important challenge for the next generation of our health system is how to better prevent and manage chronic disease.

To equip our health system to deal with the challenge of chronic disease, we need to intervene before people become unwell.

Federal Labor will embrace this challenge. We will maintain our historical and ongoing commitment to Medicare and the universality of health care. We will maintain our recognition of and support for the private sector. And we will also implement new measures to expand and shape the health system to respond to the changing needs of the community.

Federal Labor is the party of universal health care – we established Medicare which required vision, forward thinking and careful planning.

So too does the task of enhancing our health system to better prevent chronic illness.

Re-thinking primary care: the way of the future

Federal Labor believes the best way to equip our health system to deal with the challenges of the future is to re-invigorate the role of the primary care system – the front line of the health system which provides health care to local communities.

Primary care is generally provided outside hospital and is the first point of contact with the health system. Usually provided through a general practitioner in the first instance, primary care can also include care provided by nurses, community health workers, Aboriginal health workers and allied health professionals.

In the general practitioner-led model of care that operates in Australia, primary care predominantly involves treatment of non-acute conditions, management of chronic illness and some health screening. As financers of general practice services through Medicare, the Commonwealth is responsible for the provision of frontline primary care in Australia but the lines are often blurred.

There are also hundreds of state-funded community health centres and services which also provide significant primary care services, for example, community maternal and infant health nurses, and population and public health programs.

Research is showing that primary care reform is the single most important strategy for improving the health of our population.

There is international evidence to demonstrate that health systems focused on primary care and preventative health care achieve better health outcomes, including lower death rates from chronic diseases like heart disease and cancer, and lower overall cost than health systems which are focused on acute hospital care.[81]

[81] J. Doggett, *A New Approach to Primary Care for Australia,* Centre for Policy Development, June 2007.

This is because systems oriented towards primary care are likely to be better equipped to manage chronic disease, provide better continuity of care and tend to provide a greater population health focus, greater accessibility for patients, and a greater patient focus.[82]

So if we want to tackle population wide trends like increases in chronic disease, we must do it at the frontline – in the community.

Given the international evidence, it would seem that Australia is poorly served by having no national strategy for primary health care and no strategy for more effectively harnessing the benefits primary care could provide for prevention and better management of chronic disease.

A more holistic model of primary care would include a greater focus on health promotion and illness prevention, and better coordination between privately-provided GP services, and community health services run by the states and territories.

The health system of the future needs to be designed to:

- take the pressure off hospitals;
- provide more health services in the one place, thus providing greater convenience for patients;
- improve access to health services for working families; and
- provide a focus for integrated health care teams to come together in the one place and provide better services to patients outside hospitals.

There are already examples around the country of health care being provided in this way. For example the South Australian Government's GP Plus centres provide integrated, multi-disciplinary primary health care services – in other words, they bring different health professionals together (including allied health professionals) in the one setting.

The GP Plus model is focused on coordinating and improving care for people with chronic and complex conditions, and making it easier for patients with these conditions to access the variety of services they need as they are all in the one place.

The GP Plus model is designed to focus on identifying chronic disease risk factors early, to prevent or delay the onset of chronic conditions as far as possible. GP Plus centres provide health promoting activities for the local community, and a community resource for self management groups and other health and wellbeing activities. In some cases, GP Plus centres will be able to provide teaching and training opportunities for health professionals.

There are similar models up and running in other states – such as the Victorian Government's super clinics and 'Health One' centres in NSW.

Many local Divisions of General Practice successfully work across state and Commonwealth program boundaries and have developed innovative solutions to improving the coordination of care in their communities. Many also lead the way in local communities by supporting multidisciplinary care and co-operative initiatives with allied health professionals.

These kinds of services are all examples of the way we need to think about health care into the future – integrated, multi-disciplinary care focused on preventing chronic disease where that's possible and better managing it where

[82] J. Doggett, *A New Approach to Primary Care for Australia,* Centre for Policy Development, June 2007.

it's not; and care which is designed around the needs of patients (by bringing a variety of services together in the one setting) rather than the needs of the system.

Take, for example, a patient who goes to see her GP, having felt tired and run-down for months, and is diagnosed as being pre-diabetic. The patient's GP recommends the patient see a dietician, an exercise physiologist, and have an information session with a diabetes educator.

Having all these services located in the one place would be much more convenient for the patient – increasing the likelihood of the patient actually accessing the services and benefiting from their preventative potential. It would also be beneficial for health professionals, who would be better able to work together.

While some of the state and territory-sponsored services provide good examples of this model of care, to a large extent they are working in isolation from one another, and state and territory governments are limited in their capacity to invest further. The Commonwealth isn't using the leverage of its national funding programs to gain the greatest benefit from these kinds of investments.

In the absence of an overall national primary care strategy, these successes have remained isolated and have not been used to inform national policy and program development. Existing services lack the impact they could have if they formed part of a national strategy and a more comprehensive re-think of primary care focused on the meeting the challenges of the future.

Clearly, any significant re-think of the primary care system would need to be conducted carefully and sensibly, in close collaboration with health professionals, state and territory governments, other stakeholders, and the community itself.

We must build on our strengths and enhance them – not damage the valuable infrastructure, goodwill and professionalism we already have in our health sector.

But a re-think of the health system needs to happen if we are to create a next generation health system which will meet the challenges of the future.

Federal Labor's plan for prevention and primary care

A Rudd Labor Government will take action on the need to enhance the health system's focus on preventing and better managing chronic disease.

We will work in partnership with the states and territories, health professionals, and the community to help build a better preventative front end to our health system.

Under a Rudd Labor Government, keeping people well, in addition to treating, managing and caring for those who are sick, will become an express goal of Australia's health system.

Federal Labor is committed to ensuring all Australians have access to high quality health care. In particular, we understand that people with chronic illness

and families requiring high levels of care can have problems affording the services they need. Federal Labor will maintain our strong commitment to bulk-billing as an important part of ensuring that people can access health care.

We will also focus on addressing other factors that can prevent access, such as workforce shortages, the lack of coordination between different sectors of the health system and the increasing rate of chronic disease which is putting more pressure on existing health services.

An increased focus on preventive health and chronic disease management will have benefits for the whole community, but it will have particular benefits for people who are most at risk of developing preventable, chronic disease, such as Australians living in rural and remote areas, people in low socioeconomic groups, and Indigenous Australians.

Federal Labor has already announced two key policies which will help take us in this direction:

- our plans for a *Healthy Kids Check* when children are starting school, the development of a *Healthy Habits for Life Guide* for parents, and the national roll-out of the Australian Early Development Index

- our *New Directions for Indigenous Children* policy – a $261 million down-payment on Federal Labor's commitment to closing the gap in Indigenous and non-Indigenous life expectancy at birth.

Today we announce four further down-payments on this goal. Further detailed policies will be announced in the lead-up to the Federal election.

1. A National Preventative Health Care Strategy

Labor will develop a National Preventative Health Care Strategy to bring a true preventative focus to the health system. The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol.

To ensure the Strategy is robust and leads to real change in our health system, its development will be supported by a Taskforce which will provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies.

The Taskforce's work will include:

a) building an evidence base on preventative health, so we know what works and what doesn't;
b) providing support for clinicians, particularly in primary care settings to play a more effective role in preventative health, including through providing information on the effectiveness of particular treatments and interventions;
c) providing advice for policy makers on what strategies work best at population level, and on the best buys for government investment in preventative health;
d) providing advice to Government on options for better integrating preventative health practice into the Medicare Schedule and other existing government programs; and
e) build inter-governmental and public-private partnerships on preventative health.

The Taskforce's membership will comprise a range of experts including:

- academics/experts in chronic disease prevention and management;
- doctors' groups, including GP groups and specialists;
- nurses;
- allied health professionals;
- consumers;
- health insurers;
- non-government organisations with expertise in public prevention campaigns; and
- Government (Commonwealth, state, territory and local).

The Taskforce will be supported by a dedicated secretariat within the Department of Health and Ageing.

Federal Labor will allocate $3.5 million over 4 years to this initiative.

2. A new Preventative Health Care Partnership

A health care system designed for the future needs to be focused on better integrating hospitals and services provided outside of hospital, in particular through primary health care services.

Under a Rudd Labor Government, the Australian Health Care Agreements will not just be narrowly focused on hospital funding. Labor's new agreement will include a *Preventative Health Care Partnership* with the states and territories.

A Rudd Labor Government will use the next round of the Australian Health Care Agreements to explore ways of keeping people *out* of hospital, by better integrating primary care with hospital services.

Through the Australian Health Care Agreements, a Rudd Labor Government will work collaboratively with the states to identify ways of helping the states to take pressure off the hospital system, for example by increasing support and providing incentives for prevention and early intervention programs, to forestall the need for hospitalisation where possible.

Federal Labor's focus on preventive health will not mean reduced funding for acute care services.

Federal Labor wants to end the blame game over health. Federal Labor has also signalled our intention to make reforming the transition from hospital to residential aged care for those older Australians who need nursing home care a priority in the next round of the Australian Health Care Agreements.

3. Moving away from '6 minute medicine': funding prevention through general practice and modernising Medicare

Over the last decade GPs have been tied up with red tape, as numerous new, ad hoc programs have been introduced, new items have been added to the Medicare Benefits Schedule, and the Medicare rebate system has become more and more complicated.

GPs are frustrated by a health system that seems to work against them providing coordinated and preventive health care. They see the wasted resources tied up in programs that have been badly designed and implemented, which could have gone directly to patient care. For rural doctors the situation has been even more difficult as they are faced with increasing workforce shortages, higher rates of chronic disease and are often isolated from other support services.

The culture of '6 minute medicine' – whereby the current structure of the Medicare Benefits Schedule promotes a greater number of short consultations rather than fewer, longer ones – does not always produce quality outcomes for patients.

The 2003 report of the Medicare Attendance Item Restructure Working Group concluded that a restructuring of the Medicare Benefits Schedule to encourage longer patient consultations (through implementing a seven tier item restructure in place of the current four tier item structure) would 'improve the quality of health care in Australia'. But the recommendations of the Attendance Item Restructure Working Group have not been taken up.

In its first term, a Rudd Labor Government will institute a reform process to simplify Medicare and provide incentives for GPs to practice quality preventative health care, through longer consultations with patients when appropriate, and an increased focus on multi-disciplinary care from primary care teams. This will preserve clinical freedom and enable doctors to focus on what they do best – providing high quality care to patients.

The reform process will re-examine and update the work of the Attendance Item Restructure Working Group on the seven tier item restructure of the Medicare Benefits Schedule. The reform process will also consider how the current schedule can be rationalised to support doctors to provide high quality preventive care and chronic disease management more efficiently.

Included in the reform process will be consideration of various means through which doctors could be supported to provide high quality preventive care more efficiently, such as expanded access to tele-health and e-medicine. This will be of particular benefit to rural doctors and their patients.

Options for reducing the red tape burden on GPs will also be considered to maximise the time that GPs can spend with patients. These options will include streamlining and integrating current reporting requirements to reduce the need for duplication of data collection and provision.

We want to ensure that the health system supports doctors to provide high quality care to people with chronic illnesses and uses resources more efficiently.

The Attendance Item Restructure Working Group concluded that restructuring of the Medicare Benefits Schedule could be achieved on a budget neutral basis.

4. Intergenerational health reporting

The *Charter of Budget Honesty Act 1998* requires the Treasurer to publicly release and table an intergenerational report every 5 years.

Remarkably, neither the first Intergenerational Report in 2002, nor the second released in April this year, considered the impact of the chronic disease burden on the Australian economy.

In its first term of government, a Rudd Labor Government will commission the Treasury to produce a series of reports assessing the impact of chronic disease on the Australian economy, and the economic benefits of a greater focus on prevention in health care.

Any subsequent IGRs produced under a Rudd Labor Government will be required to expressly consider the chronic disease burden on the future of our

economy and the adequacy of current policy settings designed to address it.